PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man, on 16 March 2013, at HMP Highpoint

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death on 16 March 2013, of a prisoner, at HMP Highpoint. He was 51 years old. A post-mortem recorded the man's death as being due to ischaemic heart disease. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer carried out a review of the clinical care the man received in custody. Highpoint cooperated fully with the investigation.

The man had been in prison since 31 May 2012 and at Highpoint since July 2012. He had a history of alcohol and drug abuse and had been in prison a number of times before. The man reported suffering from chest pains on 10 December 2012 and in subsequent weeks. He twice reported suffering chest pain during the night but an ambulance was not called nor was other medical advice sought. A doctor found no evidence of heart problems but arranged for blood tests including one to check for heart muscle damage. He did not carry out an electrocardiogram test as would have been expected because the equipment was not working. The man last reported chest pain on 6 January 2013 but did not attend an appointment with the doctor the next day. A doctor reviewed the results of the blood tests on 5 February but did not notice that the specific test for heart muscle damage had not been carried out. The clinical reviewer notes that such a test would in any event be unusual in the diagnosis of chest pain in primary care.

On the morning of 16 March 2013, while queuing to collect his medication, the man collapsed. The emergency response was quick and healthcare staff and paramedics attempted resuscitation, but sadly it was confirmed that the man had died. The man's family learnt of his death quickly, apparently from another prisoner, but the prison would not confirm this when they telephoned for confirmation. It was some hours later before they were officially informed, and then by the police rather than staff from the prison.

The clinical reviewer was concerned that the man's reported chest pain was not well managed at Highpoint. While it is not possible to say that more effective treatment would have changed the outcome, for that reason I am not satisfied that the man's clinical care was equivalent to that he might have expected in the community. As well as identifying a need for a better understanding of the management of chest pain the investigation also indicated a need for improvements in family liaison arrangements after a prisoner's death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2013**

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SUMMARY

1. The man died on 16 March 2013, at HMP Highpoint. He was 51 years old. A post-mortem recorded his death was due to ischaemic heart disease (a condition in which fatty deposits build up in the linings of the walls of the coronary arteries causing a narrow artery and reduced blood flow to the heart muscle).

2. The man was remanded to HMP Belmarsh on 31 May 2012. During his reception health screening, it was recorded that he had history of drug and alcohol dependency. The man was referred to the prison doctor who prescribed methadone (a synthetic opiate based medication used in the treatment of heroin addiction) and diazepam (also known as valium) to support his withdrawal from alcohol. On 29 June, the man was sentenced to two years and nine months imprisonment.

3. On 25 July, the man transferred to Highpoint. Nurses saw him each day to dispense his medication and his progress was reviewed.

4. On 10 December, a nurse examined the man after he complained of chest pain and gave him indigestion tablets and pain relief. On 2 January 2013, a nurse checked him and made an appointment for him to see a doctor the next day. The doctor found no evidence of heart problems but asked for blood tests to be carried out to check his cardiac enzymes.[1] Three days later, on 6 January, the man again complained of chest pains and a nurse arranged a doctor's appointment for the following day. The man did not attend the appointment and did not mention to healthcare staff any further concerns about chest pains. When a prison doctor reviewed the results of the blood test on 5 February he did not notice that the requested check for cardiac enzymes had not been conducted. An electrocardiogram test was not carried out as the equipment was not working.

5. During the morning of 16 March, the man was standing in the medication queue when he collapsed. Emergency assistance was requested and healthcare staff attempted to resuscitate the man. An ambulance was called but at 9.51am paramedics pronounced the man dead.

6. The clinical reviewer considered that the standard of clinical care given to the man was generally not comparable to that he could have expected in the community. We make six recommendations relating to the management of chest pain, access to ECG equipment, information sharing and family liaison.

[1] Cardiac enzymes are proteins from heart muscle cells that are released into the bloodstream when heart muscle is damaged, such as during a heart attack. By measuring blood levels of cardiac enzymes, doctors can tell whether heart muscle damage has recently occurred. Measuring cardiac enzymes is often an important step in diagnosing heart attacks.

THE INVESTIGATION PROCESS

7. The investigator issued notices at HMP Highpoint informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No responses were received.

8. NHS England commissioned a clinical reviewer to carry out a review of the man's clinical care during his time in custody.

9. The investigator visited Highpoint on 20 March and met the deputy governor and spoke to staff involved in the man's care. He examined all of the man's relevant prison records, including his prison medical record. The investigator returned to Highpoint on 4 April and 17 May to conduct interviews. Initial feedback about the findings of the investigation was given to Highpoint on 21 May 2013 and subsequently followed up in writing. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.

10. HM Coroner was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. The man's family were concerned that he had been due to attend an external hospital appointment in January 2013 which was cancelled. They wanted to know why the appointment was cancelled and whether this was by the prison. They also wanted to know what medication the man had been prescribed and whether he had received this. The man's family received a copy of the draft report. No further representations were made in response to the findings.

HMP HIGHPOINT

12. HMP Highpoint is on two sites, Highpoint South which was the original HMP Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. The prison is at Stradishall, 13 miles from Bury St Edmunds in Suffolk. Highpoint is a prison for category C adult male prisoners. (Category C prisoners are those who are not judged ready for open conditions but who are unlikely to escape and do not require high security.)

13. Healthcare services are provided by Care UK. There is no inpatient facility. The healthcare centre is open from 8.00am to 8.00pm, seven days a week. Prison doctors provide cover from the hours of 8.30am to 5.00pm on weekdays and 9.00am to 12.00 noon on Saturday mornings. A telephone triage service operates during healthcare opening hours when prison doctors are not on site with an out of hours service at other times.

HM Inspectorate of Prisons

14. The last report published report on Highpoint by HM Inspectorate of Prisons (HMIP) followed an inspection in September 2012. The report found that, while there were some problems, the prison largely provided a decent and safe environment. Inspectors noted that a high proportion of patients did not attend healthcare appointments. HMIP also found that the electronic health records system (SystmOne) was not used routinely for care planning for prisoners with complex conditions.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published report the IMB had serious concerns about the management of healthcare, which had just transferred to a new provider. They hoped that new systems would help improve provision. The investigator spoke to a member of the IMB during his opening visit to Highpoint. The IMB had not had any direct contact with the man. The IMB member was positive about the prison and the professionalism of staff.

Previous deaths at Highpoint

16. The man was the second prisoner to die at Highpoint South since 2010. There are no similarities between the previous death and that of the man, or in the recommendations made.

KEY EVENTS

17. On 31 May 2012, the man was remanded into prison custody and arrived at HMP Belmarsh on the same day. This was not his first time in prison.

18. At a health screen on 1 June, it was recorded that the man was blind in his right eye, had asthma and he had started using cannabis and alcohol at 12 years of age and in his mid teens began using amphetamines, ecstasy and cocaine. The man said that he began smoking crack cocaine when he was 23 and started to use heroin when he was 26. He had overdosed twice on crack cocaine in the previous ten years. It was recorded that the man's pulse was within normal range, and his blood pressure was slightly high at 136/93.[2] The man began a standard methadone opiate withdrawal programme.

19. On 29 June, the man was sentenced to two years and nine months imprisonment for burglary and on 25 July, he transferred to HMP Highpoint (South). His methadone was dispensed daily by nurses and he was reviewed periodically by healthcare staff. It was also recorded that he was receiving pain relief for an injury to his upper left arm.

20. On 7 November, a prison doctor reviewed the man's progress. His dose of methadone was to be reduced by 2 millilitres each day for the following two weeks until it reached 10 millilitres per day where it would be maintained for the rest of his sentence.

21. On the morning of 10 December, a nurse saw the man after he complained of chest pains. His pulse was 69 bpm and blood pressure was slightly high at 160/91. He was prescribed paracetamol and antacid tablets, but no follow up was arranged.

22. At around 11.05pm on 1 January 2013, the house unit/wing observation book shows that the man pressed his cell bell complaining of chest pains. An Operational Support Grade (OSG)[3] wrote: "I told him to drink plenty of water and go special sick in the morning". The note of the morning briefing on 2 January, states that the man had complained of chest pains but when the OSG returned to check on him "said pain was better and when night staff arrived [another officer came at 3.25am] he was asleep. OSG advised to keep observations on him all night". The OSG did not seek advice about the man's chest pain and did not call an ambulance. There was no information recorded about the above incident on SystmOne (the prison medical computer system) or in the man's computerised prison record (PNOMIS).

23. On 2 January, the man was assessed by a nurse who noted that he said he had suffered from central chest pains for the previous three days. He told the nurse that sitting was the most comfortable position and he had a dull ache

[2] Blood pressure and pulse - most adults in the UK have blood pressure readings in the range from 120/80 to 140/90 and normal pulse rate is between 60 and 100 beats per minute.
[3] An Operational Support Grade (OSG) is a basic grade member of staff who will not have received the same level of training as a prison officer and he/she will have much less interaction with prisoners.

when walking. His pulse was 80 bpm and his blood pressure was recorded as 140/90 - both within normal limits. The nurse made an appointment for him to see the doctor the next day.

24. On 3 January, a prison doctor examined the man and recorded that he had experienced chest pain in his left side during the previous two days and had woken up with the pain. The doctor noted that his heart sounds were normal, his lungs were clear and there were no signs of ankle oedema (swelling, which can be a sign of heart problems). The man's pulse rate was recorded as 70 bpm and his blood pressure was 130/80, again both within normal limits. According to the record on SystmOne, the doctor requested routine blood tests to be carried out "including cardiac enzymes".

25. At around 3.20am on 4 January, the man rang his cell bell and informed the OSG that he had been experiencing chest pains for two hours and it was not getting any better. The OSG contacted the Night Orderly Officer (the person in charge of the prison at night time) who informed her that a paramedic was on their way to the prison for another prisoner so they could check on the man at the same time. The OSG recorded that the man's pain eased over time and although she informed him that the paramedic was in the prison the man said he would wait until the morning to see healthcare staff. In his statement, the Night Orderly Officer said that as he was preparing documentation for the other prisoner who was being seen by the paramedic he was made aware of the man's reported symptoms. He wrote:

> "Rather than make further calls to the out of hours or emergency services I asked the professionals currently in attendance if they would make an assessment and deal with any immediate needs. This was agreed and staff were deployed to facilitate this. I remained and prepared documentation should the man require dispatch to hospital. At some point shortly after the deployment of staff I was informed that the situation was resolved and that no prisoner escort was necessary."

There was also no information about this incident recorded on either SystmOne or on NOMIS. There is no record that the man reported to healthcare on 4 January.

26. On the morning of 6 January, the man complained of chest pains and collapsed in front of staff on the house unit. He was helped back to his cell and according to the house unit/wing observation book healthcare staff "were called and they said it was anxiety and they would not attend". Officers then took the man to the healthcare centre. He was initially seen by a nurse, at around 9.30am, who was issuing medication, and she arranged for him to be seen when she had completed her clinic. Another nurse eventually examined the man at 11.33am. She recorded his pulse was 92 bpm and blood pressure as slightly high at 160/100. The nurse also recorded that the man was becoming very anxious about his condition and he had intermittent pains in his left arm. A doctor's appointment was made for the following day but the man did not attend. The reasons were not recorded and no one followed this up.

27. The man did not attend an appointment for blood tests on 15 January, but the reason is not recorded. On 17 January, the blood tests requested by the prison doctor on 3 January were carried out. The results were reviewed and discussed with the man, on 5 February, by another prison doctor. He noted that the man's cholesterol was raised. However, he did not notice that the requested blood test for cardiac enzymes had not been done. They discussed the man's diet and agreed that the blood tests would be repeated in two months. There is no record that the man raised any further concerns about chest pains other than those he had already reported.

28. On 13 February, a prison doctor saw the man who wanted to reduce his methadone medication by 2 millilitres per week down to 4 millilitres, and then stabilise. The doctor found the man to be alert and coherent. There was nothing recorded about the man raising any concerns about chest pains.

29. On 27 February, the prison doctor recorded that the man was not coping with the reduction in his methadone and wanted to stabilise at 6 millilitres. There was no record that the man mentioned chest pains.

30. On 6 March, the prison doctor saw the man and recorded that he had settled now and was ready to reduce another 2 millilitres to 4 millilitres per day and increase his pregablin (medication used to treat nerve pain, anxiety and epilepsy). The man was still experiencing problems with shooting pain in his left arm for the injury noted when he arrived in June. The prison doctor diagnosed a frozen shoulder.

16 March 2013

31. At around 9.20am on 16 March, the man was in the medication queue when he collapsed. An officer was nearby in the corridor and immediately went to his assistance. He said they had been speaking beforehand and there was no warning of his collapse. The officer noticed that the man's breathing was sporadic and he was shaking. Another officer radioed for assistance and a code blue response (a radio code which is used to indicate an emergency where a prisoner has breathing problems). The officers put the man into the recovery position.

32. A nurse was issuing medication on the house unit and responded to the call for assistance. She found the man unconscious and not breathing. When interviewed, the nurse told the investigator that after she heard the call for assistance she realised it was only a few yards away and was able attend within a minute. She was joined by an officer and together they moved the man onto his back and started cardiopulmonary resuscitation.[4] When he started breathing again they moved him back into the recovery position. However, he stopped breathing again so they moved him onto his back and started CPR again.

[4] Cardiopulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.

33. Another nurse also responded to the code blue and brought oxygen, a defibrillator[5] and an emergency bag. He inserted an airway and gave oxygen to the man. The defibrillator was used and advised shocks which were administered. A prison doctor arrived and checked for signs of life but could not detect a heart beat. An ambulance was called at 9.23am and paramedics arrived at around 9.40am. The paramedics pronounced death at 9.51am.

Contacting the man's family

34. Before anyone had arranged to contact the man's family sometime just after 11.00am, his sister and his partner telephoned the prison to ask for confirmation that he had died. The prison was not prepared to give any information over the telephone without confirmation of who was calling, so the man's family were not told of his death at this time. The man's family were not able to say who informed them, but the prison believed it might have been a prisoner who knew the man's family.

35. The prison appointed a family liaison officer the same day. The man's sister, his nominated next of kin, lived in London and the prison asked the Metropolitan Police to inform her of his death. The police delivered the news at around 2.00pm.

36. The prison family liaison officer contacted the man's sister on 17 March. She and the prison chaplain visited the man's sister and other members of his family the next day to offer support and guidance. In line with national policy, the prison offered financial assistance towards the costs of the man's funeral, which took place on 8 April 2013.

Support for staff and prisoners

37. Prisoners on the house unit were informed of the man's death during the morning of 16 March and asked whether they required any additional support. All the prisoners in Highpoint who were subject to self-harm and suicide monitoring were reviewed in case they had been affected by the man's death. Prison managers held a meeting for staff immediately involved to share information and provide reassurance and support.

Post-mortem

38. The post-mortem examination recorded the man's death as being due to ischaemic heart disease.

[5] An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock to allow the hear to re-establish an effective rhythm.

ISSUES

Medical care

39. The clinical reviewer made a number of recommendations about clinical matters in her review, not all of which are repeated in this report but which the Head of Healthcare will need to consider. In her review, the clinical reviewer notes that the records demonstrate that the healthcare team at Highpoint were routinely in contact with the man and reviewed his care. The man had a history of substance misuse and alcohol dependence and we are satisfied that his detoxification from alcohol and drugs was appropriately managed.

Missed healthcare appointments

40. The man's family were concerned that he had missed a hospital appointment in January 2013. We have been unable to find any record of such an appointment in the man's health records and the Head of Healthcare at Highpoint said that the man had no external hospital appointments booked in January or at any time while he was at Highpoint.

41. We note that the records show the man missed a number of healthcare appointments in the prison. In written correspondence to the investigator the Head of Healthcare gave an overview of the system for healthcare appointments. She wrote that all prisoners attending for healthcare appointments should have an appointment slip delivered to them. These should be placed under their cell door to ensure that they are received so they are received by the appropriate prisoner. In addition to this a computer record of prisoners required to attend healthcare is place centrally on a computer system for Highpoint which is accessed by officers so that they have a record of which prisoners are required to attend healthcare. A prisoner cannot be made to attend a healthcare appointment, but we note that HM Inspectorate of Prisons reported at their last inspection of Highpoint that 27% of GP appointments were missed and made a recommendation about this. This would not suggest that the appointment system at Highpoint operates effectively.

42. We are concerned that the man's non-attendance was not followed up, especially as several of the appointments related to his ongoing chest pain. There is nothing in the records to show why he missed appointments, or any indication that anyone discussed this with him to find out whether he had chosen not to go or had not been aware of the appointment.

    The Head of Health should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.

Management of chest pain

43. Nurses at Highpoint undertake daily triage clinics (triage means the sorting of patients to determine the urgency and extent of healthcare required on the

basis of their illness). Treatment decisions are made on an individual nurse's interpretation of a patient's presentation, their history and symptoms. At Highpoint no protocols or procedures are used to support their decision making process. On 10 December 2012, the man attended a nurse led clinic complaining of chest pain. He was given medication to help relieve the symptoms of indigestion and no follow up was arranged.

44. During the late evening on 1 January 2013, the man informed an OSG who was on night duty that he had chest pains. The OSG advised him to drink water and to see healthcare staff the following morning. The OSG did not request an ambulance and did not raise this issue with the Night Orderly Officer or the out of hours medical service.

45. On 2 January 2013, the man was again seen in a nurse led clinic as he had experienced chest pain for the previous two days. Observations were carried out and an appointment was made for him to see the prison doctor the next day, which he attended.

46. At 3.20am on 4 January, the man rang his cell bell and again informed staff that he had been experiencing chest pains. The OSG contacted the Night Orderly Officer who informed her that as a paramedic was on the way to the prison for another prisoner he or she could check on the man at the same time. Although it appears that the man said he felt better we consider it would have been prudent to have the paramedic examine him as this was a recurrent pain. Healthcare staff were not informed about this episode of chest pain.

47. On 6 January, the man collapsed in front of staff on the house unit. Healthcare staff refused to go to the unit, saying that the man was suffering with anxiety. Prison staff were concerned about him and took him to the healthcare centre but a nurse did not examine him until two hours later. An appointment was made for him to see a prison doctor the next day but the man did not attend and the reason is not recorded.

48. Guidance from the National Institute for Health and Clinical Excellence (NICE) is that in cases of recent onset of chest pain a same day assessment by a GP is required. On the first occasion the man was seen at the nurse led clinic an appointment with a GP was not made, and on the next two occasions an appointment was made for the following day rather than the same day. We are also concerned that nursing staff refused to attend the unit when the man collapsed and that he had to wait two hours until he was seen. We make the following recommendations:

The Governor and Head of Healthcare should ensure that when a prisoner complains of chest pains they are taken to hospital or reviewed and assessed by a GP in line with NICE guidelines.

The Head of Healthcare should ensure that appropriate procedures based on NICE guidelines are developed to support clinical decision making for nurses undertaking triage clinics.

49. A prison doctor saw the man on 3 January. When interviewed, the doctor said his impression was that this was not a heart attack type of pain but in view of the man's age, some previous episodes of raised blood pressure and his smoking (all risk factors associated with heart disease) he wanted to investigate further. There was also a suggestion in the medical records that the man had previously had a stroke (although there no evidence of a formal diagnosis) and this would indicate established heart disease and further increase his risk.

50. The prison doctor ordered a routine blood test including cardiac enzyme and cholesterol. The blood sample was not taken until 17 January, as the man had not attended an earlier appointment. For unknown reasons, the laboratory did not carry out the cardiac enzyme test. The prison doctor who gave the man his blood test results on 5 February recorded that he had raised cholesterol and suggested a low cholesterol diet, but did not notice the test for cardiac enzymes had not been carried out.

51. When interviewed the prison doctor said that the test results might have initiated a referral to the rapid chest clinic. However, the clinical reviewer states that referral to rapid chest clinics do not depend on cardiac enzyme results and should not to be used to influence the decision to refer. The clinical reviewer wrote, "There is no role in General Practice for using cardiac enzymes to assess if sudden onset chest pain is cardiac in origin".

52. The prison doctor said that he would have also performed an electrocardiogram on 3 January (an ECG is a test which records the rhythm and electrical activity in the heart) but the machine for use on the south side of the prison was broken at the time. He was later informed that an ECG machine from another part of the prison could be used. However, the prison doctor decided that the blood tests would give him sufficient information. He said he would have performed an ECG if the chest pain had persisted when he next saw the man. There is no record that an ECG had been considered in the man's notes. This information was not recorded on SystmOne and it is not clear when the doctor next expected to see the man.

53. There is no evidence in his prison records that the man complained to either healthcare staff or officers of any further chest pain after 6 January, but on 6 March records show that the man was still experiencing problems with shooting pains in his left arm.

54. The clinical reviewer states that the management of the man's chest pain did not follow NICE guidelines. If an ECG is not available then emergency referral to hospital is required. We have made a recommendation above about the need to follow NICE guidelines for managing chest pain and make the following additional recommendation about the use of ECGs.

    The Head of Healthcare should ensure that the healthcare team has access to and use an ECG when indicated to inform diagnosis when prisoners present with chest pain.

Sharing information

55. The man's prison medical records were generally of good standard, appearing to be mostly contemporaneous or made soon after the event. Entries were dated, timed and assignable to an individual whose role was also recorded. However from subsequent interviews and a review of the man's other prison records it appears that not all information was shared between house unit staff and healthcare staff. This meant some information about the man's episodes of chest pain were not recorded on SystmOne so healthcare staff did not have a complete history of his health problems.

56. When health issues arise overnight, the house unit/wing record should be completed and healthcare records updated as soon as practicable. This is to ensure that healthcare staff are aware of all relevant events and are able to record them on SystmOne, the primary healthcare record.

    The Governor and Head of Healthcare should ensure that information about prisoners who are unwell is shared with healthcare staff as soon as practicable and that this is appropriately recorded on SystmOne.

The emergency response

57. The man collapsed at around 9.20am while queuing to receive his medication. Within a few minutes the officer involved had radioed for and received assistance from healthcare staff and an ambulance had been called. Paramedics arrived at the unit 20 minutes after being called and pronounced death at 9.51am.

58. From both the records and interviews with staff it appears that, after the man was discovered, all of those involved acted quickly and in a professional and considerate manner.

Informing the man's family

59. Unfortunately, it appears that the man's family received information about his death unofficially, before the prison were able to contact them. When they rang the prison for information the prison would not confirm his death because they were unable to verify who was calling. While we would normally have expected a personal visit from the prison to inform a prisoner's family of their death, in these circumstances we consider it was important to ensure they were told as quickly as possible by an official source. The prison had contact details for the man's family and could have telephoned them back in order to do this. Instead, contrary to Prison Service guidance, the prison asked the police to inform his family rather than someone from Highpoint going themselves or using the services of a prison nearer his family.

60. After calling the prison at 11.00am to try to establish whether the man had died, it was not until 2.00pm that his family received a visit from the police – over four hours after the man's death had been confirmed and three hours after his family had contacted the prison to try to establish what had happened. As his

family lived in London, only about two hours drive from Highpoint, we consider that someone from the prison should have gone to deliver the news in person if they were unwilling to confirm his death by telephone. In the event the family liaison officer did not contact the man's family by telephone until the next day and it was two days after he died before anyone from the prison went to see his family in person.

61. While we accept these were unusual circumstances we do not consider that the man's family were treated with the sensitivity we would expect or in line with the Prison Service's own instructions about informing families of a death. We make the following recommendation:

The Governor should ensure that whenever practicable staff from Highpoint visit a deceased prisoner's family in person as soon as possible after a death.

RECOMMENDATIONS

1. The Head of Health should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.

2. The Governor and Head of Healthcare should ensure that when a prisoner complains of chest pains they are taken to hospital or reviewed and assessed by a GP in line with NICE guidelines.

3. The Head of Healthcare should ensure that appropriate procedures based on NICE guidelines are developed to support clinical decision making for nurses undertaking triage clinics.

4. The Head of Healthcare should ensure that the healthcare team has access to and use an ECG when indicated to inform diagnosis when prisoners present with chest pain.

5. The Governor and Head of Healthcare should ensure that information about prisoners who are unwell is shared with healthcare staff as soon as practicable and that this is appropriately recorded on SystmOne.

6. The Governor should ensure that whenever practicable staff from Highpoint visit a deceased prisoner's family in person as soon as possible after a death.

ACTION PLAN: HMP Highpoint

No	Recommendation	Accepted/Not accepted	Response	Target date for completion
1	The Head of Health should ensure that the system for informing prisoners of healthcare appointments operates effectively and that prisoners' non-attendance is followed up with reasons recorded.	Accepted	A new system for delivering appointment details for patients has been implemented. All non-attendances are now followed up and appropriate entries made in the medical records (SystmOne).	Completed
2	The Governor and Head of Healthcare should ensure that when a prisoner complains of chest pains they are taken to hospital or reviewed and assessed by a GP in line with NICE guidelines.	Accepted	A review of the patient pathway and triage process will be undertaken to ensure appropriate and timely intervention when patients present with chest pains. During the review period all staff have been made aware of the NICE Guidelines relating to chest pain of recent onset. The relevant NICE patient pathways will be followed (including but not limited to Acute Coronary Syndrome, Stable Angina, Assessment, Diagnosis and Immediate Management of Acute Coronary Syndrome and the associated onward pathways). All healthcare professionals have been reminded regarding emergency referrals and urgent same day referrals.	31 December 2013
3	The Head of Healthcare should ensure that appropriate procedures based on NICE guidelines are developed to support clinical decision making for nurses undertaking triage clinics.	Accepted	Nurse triage algorithms are in place but will be reviewed in their entirety to ensure they support clinical decision making and reflect NICE guidelines.	31 December 2013
4	The Head of Healthcare should ensure that the healthcare team has access to and use an ECG when indicated to inform diagnosis when prisoners present with chest pain.	Accepted	A new ECG machine was ordered and is now available at the Highpoint South site, meaning that there is now an ECG machine located at both sites. Staff training has been undertaken.	Completed

5	The Governor and Head of Healthcare should ensure that information about prisoners who are unwell is shared with healthcare staff as soon as practicable and that this is appropriately recorded on SystmOne.	Accepted	A full review of information sharing and processes for passing on and recording information will be undertaken. All staff will be informed once the process has been reviewed and agreed.	31 October 2013
6	The Governor should ensure that whenever practicable staff from Highpoint visit a deceased prisoner's family in person as soon as possible after a death.	Accepted	Contingency plans will be put in place to ensure that whenever practicable staff from Highpoint visit a deceased prisoner's family in person as soon as possible after a death. In the mean time all Governor grades have been made aware of the correct procedures to follow regarding informing next of kin - in line with Prison Service guidelines.	31 October 2013